| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| WESTMINSTER VILLAGE HEALTH | 1175 MCKEE ROAD DOVER, DE 19904 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced annual & complaint survey was conducted at this facility from June 1, 2017 through June 9, 2017. The deficiencies contained in this report are based on observations, interviews, reviews of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 57. The survey sample totaled twenty-five (25).<br><br>Abbreviations/Definitions used in this report are as follows:<br>NHA - Nursing Home Administrator;<br>DON - Director of Nursing;<br>ADON - Assistant Director of Nursing;<br>DSS - Director of Social Services;<br>RN - Registered Nurse;<br>LPN - Licensed Practical Nurse;<br>UM - Unit Manager;<br>MD - Medical Doctor;<br>RNAC - Registered Nurse Assessment Coordinator;<br>CNA - Certified Nurse's Aide;<br>FSD - Food Service Director;<br>NP - Nurse Practitioner;<br>PA - Physician Assistant;<br>SW - Social Worker;<br>ADLs-activities of daily living such as bathing, dressing, and eating;<br>Always Incontinent - no episodes of continence;<br>AM - morning;<br>antiseptic - substance applied to living tissue/skin to reduce the possibility of infection;<br>BID - Twice a day;<br>BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15:<br>13-15: Cognitively intact | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/27/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 000 | Continued From page 1<br>08-12: Moderately impaired<br>00-07: Severe impairment;<br>Cognition - mental processes or thinking;<br>Conjunctivitis - eye infection;<br>Continence - control of bladder and bowel function;<br>Dementia - brain disorder with memory loss, poor judgement, personality changes and confusion;<br>DLTCRP-Division of Long Term Care Residents Protection;<br>eMAR - Electronic Medication Administration Record (in the computer);<br>EMR - Electronic Medical Record;<br>etc (et cetera) - and so forth;<br>Exploitation - making use of someone else's resources / money;<br>Extensive Assistance - resident performed part of the activity but needed help 3 or more times with: weight bearing support; full staff performance during part (but not all);<br>Ferrous Sulfate - iron supplement;<br>Frequently Incontinent [urine] - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day period;<br>Gerilanta (Mylanta) - antacid used for heartburn and indigestion;<br>Glucosamine-Chondroitin - supplement used to promote joint health;<br>HS - At bedtime;<br>Hydrogel Amorphous wound dressing-water-based gel dressing used for a variety of wounds;<br>Immobility - not being able to move around;<br>i.e.- that is;<br>Incontinence - loss of control of bladder and/or bowel function;<br>inhalation - the drawing of air or other substances into the airways and lungs; | F 000 | | |

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| F 000 | Continued From page 2<br>LTC - Long Term Care Unit;<br>MDS (Minimum Data Set) - standardized assessment used in nursing homes;<br>Metoprolol Succinate - long-acting drug used to treat high blood pressure that affects the heart and blood flow through the arteries and veins;<br>mg (milligrams) - metric unit of weight;<br>Moderate Cognitive Impairment - decisions poor, cues / supervision required;<br>Occasionally Incontinent [urine] - less than 7 episodes of incontinence;<br>Ombudsman - person who investigates resident complaints and helps to achieve agreement with the facility;<br>OOB - Out of bed;<br>OT (Occupational Therapy) - rehabilitation needed for completion of ADLs;<br>Physician Order Sheet (POS) - monthly report of active physician orders;<br>PM - evening;<br>PO - Physician's Order;<br>POs-Physician's Orders;<br>Pericare- cleansing the area around where urine [pee] could collect;<br>POA - Power of Attorney;<br>Point of Care - electronic charting system for CNAs;<br>Pressure Ulcers (PUs) - sore area of skin that develops when blood supply to it is cut off due to pressure;<br>PRN - As needed;<br>Restorative-restore to prior level of function;<br>Tramadol - drug used to treat pain;<br>Triamcinolone cream 1% - used to treat a variety of skin conditions, reducing swelling, itching, and redness;<br>Toileting schedule-taking a resident to the toilet at scheduled times;<br>Santyl-onitment to remove cells; | F 000 | | |

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| F 000 | Continued From page 3<br>SBAR (Situation, Background, Assessment, Recommendation) - tool to communicate with other members of the health care team;<br>STAT - immediately;<br>Sodium Chloride- salt;<br>Suture - stitches;<br>%-percentage;<br>Voiding Diary - a record of voiding (urinating) for 72 hours and/or 3 days. | F 000 | | |
| F 225 SS=E | 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>483.12(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.<br><br>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. | F 225 | | 7/19/17 |

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| F 225 | Continued From page 4<br>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of other facility documentation it was determined that the facility failed to promptly identify and report financial | F 225 | A) R58 funds have been reviewed and proper authorities have been notified.<br>B) Current resident funds will be | |

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| F 225 | Continued From page 5<br>exploitation to the Division of Long Term Residents Protection (DLTCRP) for one (R58) out of 25 sampled residents. Findings include:<br><br>2009 - Facility policy entitled "Abuse Neglect or Exploitation" (last approved 2017) documented that:<br>- Allegations of abuse, neglect, mistreatment of residents or misappropriation of property shall be reported immediately to the supervising nurse . . . and documented on an Incident Report.<br>- Family members or visitors suspected of abuse, neglect or misappropriation shall be required to leave the facility immediately. Future visitation may be affected by the outcome of the full investigation of the situation.<br>- Investigative skills shall be used to identify injuries, provide treatment of identified injuries, to determine circumstances that might contribute to incident. Materials found pertinent to the investigation shall be released to proper authorities upon request after consultation with [Name of ] administrative office staff.<br>- In Delaware, the administrator or designee is responsible to notify the DLTCRP. Notify law enforcement agency about the following incidents: allegations of physical abuse, sexual abuse, misappropriation of resident's property and deaths by unusual circumstances. Notification of the DLTCRP immediately by telephone or electronically by email. Notification of the Executive Director and the appropriate clinical team members.<br><br>During the Stage 1 resident interview with R58 on 6/1/17 at 12:08 PM, the resident responded "No" when asked "Does the facility let you know how much money you have in your account?" The resident explained that he began allowing the | F 225 | reviewed and any discrepancy indicating misappropriation of funds will be investigated and reported to proper authorities.<br>C) Nursing Home Administrator, business office manager, and business office assistant will be educated regarding reporting requirements for misappropriation of funds through web based training modules.<br>D) An audit will be completed by the Business Office Coordinator or designee weekly for 4 weeks and then monthly for 2 months of 3 resident records for possible misappropriation of funds and if proper reporting was completed. Audit results will be forwarded to the Quality Assurance Process Improvement committee for review. | |

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| F 225 | Continued From page 6<br>facility to manage his funds in December, 2016.<br><br>During an initial interview on 6/2/17 around 1:30 PM with E10 (Finance) regarding personal funds E10 provided a listing of residents with a personal funds account. R58 received Medicaid benefits and after $50 was removed from his/her monthly Social Security check for resident personal use, the balance of the check was the amount designated as patient pay for the nursing facility. E10 stated that R58 had an outstanding balance "around $8,000" since the patient pay was not received for many months before the facility took over managing R58's funds.<br><br>During an interview with R58 on 6/6/17 at 12:55 PM, R58 revealed:<br>- E10 informed the resident in November 2016 that 10 to 11 months of bills had not been paid.<br>- R58's brother took over managing the funds and paying the bills after the resident's mother was not capable.<br>- Wonder why they "waited so long to tell me" he [brother] wasn't paying.<br>- Asked the surveyor to find out the exact amount of the balance due.<br><br>During a follow-up interview with R58 on 6/8/17 at 9:30 AM, R58 said:<br>- Brother isn't healthy and "used my money to pay bills" when his business was failing.<br>- "I didn't push it with my brother cause he takes care of mom."<br><br>During a telephone interview with E10 on 6/8/17 around 2:00 PM [E10 was at another facility] E10 revealed:<br>- R58's "mom took care the bills for five years," but when her condition worsened, the brother | F 225 | | |

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| F 225 | Continued From page 7<br>took over.<br>- Payments stopped in January, 2016.<br><br>During an interview with E1 [NHA] on 6/9/17 at 3:10 PM to request the investigative file, E1 said he would check with E10. When asked if the financial exploitation was reported to the State Agency, E1 responded s/he would "check with E10 since "I was not involved then."<br><br>During an interview with E1 on 6/9/17 at 11 AM to inquire about the status of an incident report, E1 would need to call E10 to verify.<br><br>On 6/9/17 around 12:00 PM E1 provided a printout of Collection Notes which revealed communication between corporate billing office and facility which included:<br>- 8/30/16: first entry informing E10 of $4,908 outstanding balance.<br>- 1/17/17: Resident account opened 12/22/16. Brother paid $1,386.91 on 12/30/16.<br>- 2/6/17 (11:30 AM): E10 wrote brother paid $866.04 (R58's February check) and brother had no plans or means of paying back the monies used for his own purposes and resident request we not contact authorities.<br><br>The facility failed to:<br>- Promptly identify non-receipt of R58's patient pay for 7 months which permitted the financial exploitation to continue.<br>- Report R58's financial exploitation to the State Agency.<br>- Follow their policy by not completing an incident report about this issue.<br><br>These findings were reviewed with E1 and E2 (DON) on 6/9/17 at 2:50 PM. | F 225 | | |

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| F 280 SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--<br><br>(i) Facilitate the inclusion of the resident and/or resident representative.<br><br>(ii) Include an assessment of the resident's strengths and needs.<br><br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care. | F 280 | | 7/19/17 |

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| F 280 | Continued From page 9<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(2) A comprehensive care plan must be-<br><br>(i) Developed within 7 days after completion of the comprehensive assessment.<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. | F 280 | | |

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| F 280 | Continued From page 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, observations, and clinical record reviews as well as a review of other facility documentation, it was determined that the facility failed to revise/update approaches and/or goals on the care plan to reflect changes in care/services for 3 (R63, R58, and R12) of 25 stage 2 sampled residents. Findings include:<br><br>1. A review of R63's clinical record revealed the following:<br><br>R63 had an identified problem area related to behaviors.<br>-Goal was for R63 to have no more than 20 episodes "of fear of or anger towards others" per month through the next 90 days." Initiated 12/29/16.<br>The goal is not measurable as written because the categories of fear and anger are broad and are not well defined. The facility did not identify specific behaviors to monitor related to fear and anger.<br><br>-Approaches included but were not limited to "insure 2 staff members are present for care and services to minimize risk of false accusations." Initiated 12/29/16.<br><br>Surveyor observations and interviews revealed:<br><br>On 6/6/17 between 7:03 AM and 7:25 AM the surveyor observed that E9 (CNA) went in to R63's room to assist R63 with getting out of bed and morning care. No other staff were observed at that time. R63 wanted to get ready because he/she had an appointment out of the facility. | F 280 | A) R63 care plan goal has been updated to reflect measureable and specific behaviors. R58 care plans have been updated to reflect current status and needs. R 12 care plan has been updated to reflect current care/medications.<br>B) Current resident care plans will be reviewed by the RNAC/LNC or designee to assure that they have measurable goals, are current, and interventions updated to reflect current care needs.<br>C) Registered Nurse Assessment Coordinators and Licensed Nurses will be educated on how to document care plan goals with measurable outcomes. Education will also include the need to resolve and revise care plans timely to reflect current care needs.<br>D) An audit will be completed weekly by the RNAC/LNC or designee for 4 weeks and the monthly for 2 months of 5 resident care plans to assure that goals are measurable and that care plans are current and interventions reflect current care needs. Audit results will be forwarded to the Quality Assurance Process Improvement committee for review. | |

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| F 280 | Continued From page 11<br>On 6/9/17:<br>- 7:15 AM the surveyor observed, E9 went in to R63's room and shut the door.<br>- 7:23 AM observed R63 being pushed in wheelchair by E9 from his/her room to the shower room.<br>- 7:25 AM E8 told the surveyor that E9 was R63's caregiver for the day.<br>- 9:10 AM in room per resident showered by one aide this morning<br>- 9:12 AM E9 reported to the surveyor that he/she showered R63 this morning and there were no other staff with E9. E9 stated that R63 only required the assist of one when showering.<br>- 10:28 AM during an interview with the surveyor, E4 (RNAC) stated that R63's behavior care plan had not been revised since initiated.<br>-10:39 AM during an interview with the surveyor, E5 (DSS) acknowledged that the plan had not been updated and then gave the surveyor a new copy that showed the approach requiring two staff be present during care and services was resolved on 6/9/17.<br><br>2. Observation of R58 during stage 1 (6/1/17 at 10:00 AM through 6/2/17 at 3:00 PM) discovered the resident has teeth and no dentures nor did the resident have any sutures on the forehead.<br><br>Review of R58's care plan from 1/11/17 revealed care plan problem for:<br>A. ADLs included the intervention to provide oral care with AM and PM care. Place dentures in AM and remove at HS (bedtime). Remove during naptime and ensure placement for meals. Assess for comfort levels and report refusals or problems noted in oral cavity to nurse. [The resident did not have dentures].<br>B. Conjunctivitis included the following | F 280 | | |

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| F 280 | Continued From page 12<br>interventions: Medicate with antibiotic drops; Clean eyes; Monitor resident for pain and / or discomfort. [The resident's active medication list did not include antibiotic eye drops.]<br>C. Falls included an intervention to Monitor sutures to forehead for signs and symptoms of infection. Remove sutures as ordered. [The resident had no evidence of forehead sutures.]<br><br>1/27/17 - Assessment for infection tracking for eye infection documented the eye infection was resolved.<br><br>During an interview with E12 (LPN) on 6/6/17 at 12:10 PM to review the ADL and conjunctivitis care plan issues E12 confirmed the resident did not have dentures, stating "the person who entered that is not here anymore." E12 confirmed the conjunctivitis care plan should have been resolved on 1/27/17. E12 made the appropriate changes to the care plan at 12:15 PM on 6/6/17.<br><br>During an interview with E12 on 6/8/17 at 12:00 PM to review the fall care plan, E12 confirmed the intervention about forehead sutures should have been resolved / removed. E12 made the change to the care plan.<br><br>3. A review of R12's clinical record revealed the following:<br><br>-Care Plan, last revised 2/1/17 - Approach: Receives tramadol routine.<br><br>-No POs for tramadol could be found.<br><br>On 6/9/17 at 8:47 AM E3 (ADON) confirmed that R12 does not have (past or current) POs for tramadol. | F 280 | | |

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| F 280 | Continued From page 13<br><br>The above findings were discussed at the exit conference on 6/9/17 at approximately 2:50 PM with E1 (NHA) and E2 (DON). | F 280 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interview it was determined that the facility failed to provide necessary hand hygiene and toileting according to the care plan for one (R96) out of 25 sampled residents. Findings include:<br><br>Review of R96's clinical record revealed:<br><br>10/14/14 - Diet Communication Form documented the resident required finger foods for all meals.<br><br>1/3/15 - Care plan problems for:<br>- Incontinence included the following intervention: Establish a regular toileting regime while awake. Staff will toilet during AM / PM care, after breakfast, lunch, dinner and before bed and as needed thru the night.<br>- Nutrition included the intervention to assist with meals / set up as needed.<br>- Risk for pressure ulcers included the intervention to turn and reposition frequently as tolerated, ensure to lift resident and not slide; Provide toileting assist as required or incontinence care when needed. | F 312 | A) R96 has been assessed and has no evidence of skin issues and/or gastrointestinal symptoms.<br>B) Current residents will be assessed by the DON/ADON or designee for any skin issues and/or gastrointestinal symptoms.<br>C) Nursing staff will be educated on following care plan interventions for toileting schedules and resident hand hygiene prior to meals.<br>D) An audit will be completed by the DON/ADON or designee weekly for 4 weeks and the monthly for 2 months of 5 residents to assure that toileting schedule was followed and that proper hand hygiene was completed prior to meals. Audit results will be forwarded to the Quality Assurance Process Improvement committee for review. | 7/19/17 |

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| F 312 | Continued From page 14<br><br>3/27/17 - Quarterly MDS Assessment documented the resident had moderate cognitive impairment, required extensive assistance for locomotion, transfer and toileting, and was independent with eating.<br><br>5/16/17 - Care plan problem for ADL Function recorded R96 was not a candidate for restorative due to combative behavior during care (added 12/1/16). The goal was that the resident would receive assistance with all ADLs as required. Interventions included: Anticipate resident needs. Resident unable to make needs known; Transfer assist stand pivot [turn] with two staff; Resident enjoys sitting at window in dining room and watch the cars go by.<br><br>Observations of R96 throughout the survey revealed:<br>- 6/1/17: Seated in wheelchair by window in dining room continuously between 10:00 AM and 1:15 PM without being toileted / repositioned or receiving/attempting hand hygiene prior to eating lunch of finger foods.<br>- 6/2/17: Immediately after breakfast staff pushed R96 to the activity area without being toileted / repositioned. Resident was returned to dining room for lunch without hand hygiene prior to eating lunch with fingers.<br>- 6/5/17: At dining room table finishing breakfast around 9:15 AM. Remained at same location in the dining room until lunch. No hand hygiene attempted / performed prior to eating lunch using fingers.<br>- 6/6/17: At 9:00 AM seated in wheelchair at preferred table in dining room finishing breakfast using fingers to eat sausage and dry cereal. Continuous observation to 12:37 PM found no | F 312 | | |

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| F 312 | Continued From page 15<br>toileting/positioning after breakfast nor hand hygiene attempted / performed prior eating lunch consisting of finger foods. At 2:20 PM was in bed asleep.<br>- 6/8/17: 9:40 AM sitting in DR [dinning room] and eating last pieces of cut up muffin. Taken immediately after eating to TV lounge to watch television without toileting / repositioning. At 11:50 AM returned to the dining room for lunch containing finger foods. No hand hygiene attempted / performed.<br><br>During an interview with E12 (LPN) on 6/8/17 at 11:42 AM E12 stated that hand hygiene should be performed using wipes prior to meals. When surveyor stated that no hand hygiene was observed throughout the survey E12 said "Ok."<br><br>During an interview 6/9/17 around 9:00 AM with E11 (CNA) who routinely cares for R96, E11 confirmed that the resident was toileted upon rising and again after lunch. When asked how hand hygiene was usually performed for residents, E11 responded that wipes are used. When the surveyor stated that no hand hygiene was observed throughout the survey, E11 had no comment.<br><br>These findings were reviewed with E1 (NHA) and E2 (DON) on 6/9/17 at 2:50 PM. | F 312 | | |
| F 315 SS=D | 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>(e) Incontinence.<br>(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is | F 315 | | 7/19/17 |

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| F 315 | Continued From page 16<br>or becomes such that continence is not possible to maintain.<br><br>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br><br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and<br><br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview it was determined that for two (R47 and R92) out of 25 sampled residents the facility failed to ensure care and services were provided to improve or maintain bladder continence. Findings include:<br><br>The facility policy for Bowel and Bladder training | F 315 | A) R47 has been discharged and R 92's continence is currently being assessed with a 3 day bowel and bladder tracker and toileting plans have been initiated as appropriate.<br>B) An audit of current residents will be completed by the DON/ADON or | |

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| F 315 | Continued From page 17<br>last approved 2/18/15 documented under guidelines "using the electronic health record system for voiding patterns for 3 days to determine patterns of incontinence" and under procedure "establish an individualized bowel and bladder program for each resident".<br><br>1. The following was reviewed in R47's clinical record:<br><br>3/7/17 - Admitted to the facility post hospitalization.<br><br>3/7/17 - Bladder and Bowel Evaluation indicated a prior history of incontinence, resident can communicate his/her need for toileting / assistance, resident able to participate in training, always incontinent of bladder, supervision with toileting, and no incontinence product indicated.<br><br>3/12/17 - Bladder and Bowel Evaluation indicated a prior history of incontinence, resident can communicate his/her need for toileting / assistance, resident able to participate in training, occasionally incontinent of bladder, toileting ability not assessed, and large adult brief.<br><br>3/14/17 - Admission/ 5-day MDS indicated the resident was occasionally incontinent of urine, required extensive assistance with toileting and moderately cognitively impaired.<br><br>3/17 - 4/24/17 - Admission to a acute psychiatric [facility dealing with mental disorders] facility per progress notes.<br><br>CNA EMR documentation revealed:<br>March 8-17, 2017 - 21/29 [21 out of 29] shifts continent | F 315 | designee to determine if there has been a decline in continence. If a decline identified an evaluation will be completed to determine appropriate toileting programs.<br>C) Education will be completed on appropriate bowel/bladder documentation and evaluation for toileting needs to identify and address potential decline.<br>D) An audit will be completed by the DON/ADON or designee weekly for 4 weeks and the monthly for 2 months of 5 residents to assure there has been appropriate documentation of continence and if a decline has occurred that appropriate toileting plans were initiated. Audit results will be forwarded to the Quality Assurance Process Improvement committee for review. | |

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| F 315 | Continued From page 18<br>April 24 - 30, 2017 - 3/21 shifts continent<br>May 2017 - 4/93 shifts continent<br>June 1 - 7, 2017 - no continent episodes<br><br>4/24/17 - Bladder and Bowel Evaluation indicated prior history of urinary incontinence, resident can communicate his/her need for toileting / assistance, frequently incontinent, requires extensive assistance with toileting and uses adult brief.<br><br>5/4/17 - Interim care plan for alteration in bowel and bladder elimination as related to incontinence with approaches that included complete 3 day Bowel and Bladder Tracker, complete Bladder and Bowel Evaluation to assist in appropriate interventions, teach and encourage routine voiding, assist with toileting as needed, peri-care after incontinent episode, and use of incontinent briefs as needed.<br><br>5/9/17 - Bladder and Bowel Evaluation indicated no prior history of incontinence, resident can communicate his/her need for assistance, always incontinent, totally dependent for toileting, and no incontinence products.<br><br>5/16/17 - Bladder and Bowel Evaluation indicated no prior history of incontinence, resident can communicate his/her need for assistance, always incontinent of bladder, extensive assistance with toileting and no incontinence products.<br><br>5/16/16 - 14 - day MDS documented moderately cognitively impaired, extensive assistance with toileting and frequently incontinent of bladder.<br><br>6/08/17 10:21 AM - Interview with E13 (LPN) revealed that on admission in March R47 knew | F 315 | | |

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| F 315 | Continued From page 19<br>sometimes if she needed to go to the bathroom but believed she was more incontinent then continent. E13 also stated that she did not have a 3-day voiding diary assessment and did not feel the resident was cognitively able to participate in a toileting program.<br><br>6/08/17 11:29 AM - Interview with E3 (ADON) revealed that on admission the resident was assessed as occasionally incontinent of urine and that she was unsure if there was a voiding diary.<br><br>6/8/17 2:10 PM - Interview with E14 (CNA) who was attending to the resident since she moved to the long term care unit on 5/25/17, stated that the resident is a mechanical lift transfer and can use a bed pan, sometimes R47 knows when she has to go and is not on a scheduled toileting program. She further stated that she has been continent of bowel on the bed pan but has been wet before using the bed pan.<br><br>6/08/17 3:16 PM - Interview with E3 revealed that the facility did not currently have a Bowel and Bladder program in place but have currently purchased a package program that they are preparing to implement.<br><br>2. Review of R92's clinical record revealed the following;<br><br>12/25/16 - An admission MDS assessment documented R92's bladder continence as frequently incontinent.<br><br>3/21/17 - A bowel and bladder assessment form documented that R92:<br>- can communicate need for toileting<br>- can communicate need for assistance | F 315 | | |

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| F 315 | Continued From page 20<br>- able to participant in training<br>- always continent of bladder<br>- required supervision for toileting (oversight, monitoring, encouraging, verbal prompting or cuing provided)`<br>- w/c [wheel chair] bound<br>- no set up for toileting support<br>- no prior history of bladder incontinence.<br><br>3/23/17 - A quarterly review assessment documented R92's bladder continence as always incontinent (no episodes of continent voiding).<br><br>CNA EMR documentation revealed:<br>December 19-31, 2016 - 6/39 shifts continent<br>January 1-31, 2017 - 8/93 shifts continent<br>February 1-28, 2017 - 5/84 shifts continent<br>March 1-31, 2017 - 7/93 shifts continent<br><br>A bladder elimination related to incontinence care plan was last updated 5/2/17 to include the interventions toilet and/or change padding and give proper hygiene.<br><br>During an interview on 6/8/17 at 2:28 PM with E15 (LPN) when asked did the facility perform voiding diaries or have a toileting program she stated "not that I know of".<br><br>During an interview on 6/8/17 at 2:43 PM with E16 (RN) supervisor it was reported that R92 was continent and E16 stated "I don't remember her being incontinent".<br><br>During an interview on 6/8/17 at 2:50 PM with E17 (CNA ) it was reported that R92 was incontinent of bladder "all of the time".<br><br>During an interview on 6/8/17 at 3:08 PM with E3 | F 315 | | |

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| F 315 | Continued From page 21<br>(ADON) it was confirmed that the facility did not have a toileting program in place.<br><br>During an interview on 6/9/17 at 8:11 AM with E3 (ADON) it was confirmed that there was no implementation of interventions in response to R92's decline in bladder function and that the facility at this time does not have a bladder program.<br><br>During an interview on 6/9/17 at 8:28 AM with E4 (RNAC) it was reported that the care plan intervention added 5/2/17 was in response to R92's decline in bladder continence. E4 explained that upon assesment of a decline in bladder function the staff nurses are notified during the care plan meeting and the care plan is reviewed to see if any interventions can be added.<br><br>R92 experienced a decline in bladder continence between December 2016 to March 2017 MDS assessment. The facility failed to provide evidence of a response to the decline or preventive measures to prevent further decline due to their current lack of a toileting program.<br><br>These findings were reviewed with E1 (NHA) and E2 (DON) on 6/9/17 at 2:50 PM. | F 315 | | |
| F 372 SS=E | 483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY<br><br>(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:<br>Based on observation, it was determined that garbage was not properly disposed of in in this facility. There are six observations over four days of outside garbage receptacles having open lids, | F 372 | A) No residents were affected by the garbage can lids not being tightly secured.<br>B) All outdoor garbage areas have been reviewed by the Director of Dining and | 7/19/17 |

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| F 372 | Continued From page 22<br>for a total of 13 out of 72 garbage receptacles having open lids . Findings include:<br><br>Observations were made on:<br><br>-6/1/17 at 8:45 AM of two out of 12 garbage receptacles lids not being tightly secured<br>-6/5/17 at 3:20 PM of two out of 12 garbage receptacles lids not being tightly secured<br>-6/6/17 at 8:33 AM of one out of 12 garbage receptacles lids not being tightly secured<br>-6/6/17 at 3:30 PM of two out of 12 garbage receptacles lids not being tightly secured<br>-6/8/17 at 8:05 AM of four out of 12 garbage receptacles lids not being tightly secured<br>-6/8/17 at 4:00 PM of two out of 12 garbage receptacles lids not being tightly secured<br><br>Findings were reviewed with E21 (FSD) on 6/9/17 at 11:24 AM. E21 will discuss with the environmental department as garbage is a responsibility of both departments.<br><br>These findings were reviewed with E1 (NHA) and E2 (DON) on 6/9/17 at 2:50 PM. | F 372 | Director of Environmental Services and all receptacles have lids that can be tightly secured.<br>C) Dietary and Environmental Service staff will be educated on the need to keep garbage can lids secured tightly. Signage has been placed on each receptacle as a reminder.<br>D) An audit will be completed by the Director of Dining Services/Director of Environmental Services or designee weekly for 4 weeks and the monthly for 2 months to assure that garbage lids are tightly secured. Audit results will be forwarded to the Quality Assurance Process Improvement committee for review. | |
| F 386 SS=D | 483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS<br><br>(b) Physician Visits<br>The physician must--<br><br>(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;<br><br>(2) Write, sign, and date progress notes at each visit; and | F 386 | | 7/19/17 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 386 | Continued From page 23<br>(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview it was determined that for one (R47) out of 25 sampled residents the facility failed to ensure the physician signed orders for the prescribed care. Findings include:<br><br>1. Review of R47's clinical record revealed; R47 was admitted to the facility on 3/7/17. Although there were physician's orders in the EMR there were no physician signed admission orders on the record. The EMR does not have electronic signatures.<br><br>4/24/17 - Readmission to the facility from a psychiatric facility. There were no physician's orders other then those in the EMR.<br><br>April 2017 and May 2017 - No signed or unsigned physician's orders available on the clinical record only orders entered into EMR by nursing.<br><br>6/09/17 9:11 AM - Interview with E3 (ADON) revealed that signed physician orders for admission, re-admission, April 2017 and May 2017 could not be located. It was confirmed that the facility was not using an electronic signature and that the physician was signing the orders on paper. No further explanation for the missing physician orders was offered.<br><br>These findings were reviewed with E1 (NHA) and E2 (DON) on 6/9/17 at 2:50 PM. | F 386 | A) R47's current physician orders have been reviewed and signed by the physician.<br>B) Current resident records will be reviewed by the DON/ADON or designee to assure that their orders are current and have been signed by the physician.<br>C) Physicians and Licensed nursing staff will be educated on the need for the physician to review and sign orders at the time of admission, re-admission, and with any new verbal/telephone orders. The orders can be signed electronically or on the printed paper orders.<br>D) An audit will be completed by the DON/ADON or designee weekly for 4 weeks and the monthly for 2 months for 5 resident records to assure that physician orders have been obtained and are signed in a timely manner. Audit results will be forwarded to the Quality Assurance Process Improvement committee for review. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085032 | A. BUILDING _____ B. WING _____ | 06/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 431 | Continued From page 24 | F 431 | | |
| F 431 SS=E | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>(h) Storage of Drugs and Biologicals. | F 431 | | 7/19/17 |

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| F 431 | Continued From page 25<br>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and a review of other facility documents, it was determined that the facility failed to ensure medications and treatments in residents' rooms were secured properly as required and in accordance with the facility's policy. This deficient practice was evident for 6 (R35, R49, R63, R160, R88, & R7) of 25 sampled stage 2 residents. Findings include:<br><br>The facility's medication storage policy (2011) documents that all medications and biologicals are stored safely, securely, and according to the manufacturer's recommendations. Medications and biologicals are to be "accessible only to license nursing personnel and pharmacy personnel" lawfully authorized to administer medications.<br><br>Surveyor observations revealed:<br><br>6/1/17 at 12:06 PM - a tube of triamcinolone | F 431 | A) Residents who were cited have had medications and treatments secured properly.<br>B) An audit was completed for all resident rooms by the DON/ADON and designees and all medications were secured.<br>C) Education was completed for Licensed Nursing Staff on the need to secure all medications and treatments.<br>D) An audit will be completed by the DON/ADON or designee weekly for 4 weeks and the monthly for 2 months for 5 resident medication storage areas to assure that medications and treatments were secured properly. Audit results will be forwarded to the Quality Assurance Process Improvement committee for review. | |

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| F 431 | Continued From page 26<br>cream 1% and a small container of hydrogel amorphous wound dressing were found in an unlocked wall cabinet in R49's room.<br><br>6/1/17 at 12:20 pm - a bottle of gerilanta for indigestion and a tube of trimcinolone cream 1% were found in an unlocked wall cabinet in R63's room.<br><br>6/1/17 at 12:27 PM - a bottle of Chlorhexicine 0.12% (antiseptic rinse), that expired on 5/31/17, was found in an unlocked wall cabinet in R88's room<br><br>6/1/17 12:37 PM - two vials of 0.9% sodium chloride inhalation solution, without further labeling were found in an unlocked wall cabinet in R7's room<br><br>6/2/17 between 9:42 AM and 10:23 AM - the surveyor noted the same treatments and/or medication were found in unlocked wall cabinets in R49's and R63's rooms.<br><br>6/5/17 at 11:09 AM - ferrous sulfate 325 milligram (mg) tablets (iron supplement), Glucosamine-chondroitin 750-600 mg tablets (supplement), and metoprolol succinate ER [extended release] 25mg tabs (antihypertensive medication) in an unlocked medication cabinet in R160's room. There were multiple single packages of each of the medications.<br><br>6/5/17 at 11:14 AM - a tube of santyl ointment found in an unlocked wall cabinet in R35's room.<br><br>During an interview with the surveyor on 6/05/17 at 11:20 AM, E7 (LPN) was asked about the medication cabinet in R160's room which the | F 431 | | |

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| F 431 | Continued From page 27<br>surveyor found one side was unlocked and had medications in it. E7 stated that part of the cabinet would not close at times and probably E6 [RN ]was not aware. E 7 stated that E6 was responsible for R160's medication for the day. E6 did come into the room and observed that 1/2 the medication cabinet was not secure.<br><br>According to a typed facility document (undated) from E1 (NHA) the medications were secured in R160's room in the other 1/2 of the cabinet that locked. A repair order was submitted and maintenance fixed the cabinet the same day (6/5/17). The facility staff did an audit (sweep) on 6/5/17 of all resident rooms to ensure that medications and treatments were secured in locked medication cabinets and not in wall cabinets that did not lock.<br><br>During a telephone interview with the surveyor on 6/8/17 at 11:20 AM, E8 (LPN) stated that on 6/5/17 she was told to check all medication cabinets and wall cabinets on the 400 hallway to ensure that medications and treatments were secured. E8 stated that she found two products for treatments that were not secured in two different rooms.<br><br>In a separate interview with the surveyor on 6/9/17 10:17 AM, E8 stated that all medications and treatments are to be stored in the locked medication cabinets in resident rooms or on the medication carts.<br><br>The above findings were discussed at the exit conference on 6/9/17 at approximately 2:50 PM with E1 [NHA] and E2 (DON). | F 431 | | |

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS -DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT



FACILITY: Westminster Village Health

DATE SURVEY COMPLETED: June 9, 2017

| | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|---|---|---|
| | **The State Report incorporates by reference and also cites the findings specified in the Federal Report.**<br>An unannounced annual & complaint survey was conducted at this facility from June 1, 2017 through June 9, 2017. The deficiencies contained in this report are based on observations, interviews, reviews of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 57. The survey sample totaled twenty-five (25). | | |
| **3201** | **Regulations for Skilled and Intermediate Care Facilities** | | |
| **3201.1.0** | **Scope** | | |
| **3201.1.2** | **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**<br><br>**This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on June 9, 2017: F225, F280, F312, F315, F372, F386, and F431. | Cross reference to the CMS 2567L POC Submitted 6/27/17 for F225, F280, F312, F315, F372, F386 and F431 | |

Provider's Signature NHA Title NHA Date 6/27/17